110TH CONGRESS
2d Session
HOUSE OF REPRESENTATIVES
REPORT
110–786

VETERANS' HEALTH CARE POLICY ENHANCEMENT ACT OF 2008

JULY 29, 2008.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. FILNER, from the Committee on Veterans' Affairs, submitted the following

R E P O R T

[To accompany H.R. 6445]

[Including cost estimate of the Congressional Budget Office]

The Committee on Veterans' Affairs, to whom was referred the bill (H.R. 6445) to amend title 38, United States Code, to prohibit the Secretary of Veterans Affairs from collecting certain copayments from veterans who are catastrophically disabled, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

CONTENTS

69–006

AMENDMENT

The amendments are as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Veterans' Health Care Policy Enhancement Act of 2008".

SEC. 2. PROHIBITION ON COLLECTION OF CERTAIN COPAYMENTS FROM VETERANS WHO ARE CATASTROPHICALLY DISABLED.

(a) PROHIBITION ON COLLECTION OF COPAYMENTS AND OTHER FEES FOR HOSPITAL OR NURSING HOME CARE.—Section 1710 of title 38, United States Code, is amended—

(1) by redesignating subsection (h) as subsection (i); and

(2) by inserting after subsection (g) the following new subsection (h):

"(h) Notwithstanding any other provision of this section, a veteran who is catastrophically disabled shall not be required to make any payment otherwise required under subsection (f) or (g) for the receipt of hospital care or nursing home care under this section.".

(b) EFFECTIVE DATE.—Subsection (h) of section 1710 of title 38, United States Code, as added by subsection (a), shall apply with respect to hospital care or nursing home care provided after the date of the enactment of this Act.

SEC. 3. EXPANSION OF AUTHORITY OF SECRETARY OF VETERANS AFFAIRS TO PROVIDE COUNSELING FOR FAMILY MEMBERS OF VETERANS RECEIVING NONSERVICE-CONNECTED TREATMENT.

Section 1782(b) of title 38, United States Code, is amended by striking "if—" and all that follows and inserting a period.

SEC. 4. COMPREHENSIVE POLICY ON PAIN MANAGEMENT.

(a) COMPREHENSIVE POLICY REQUIRED.—Not later than October 1, 2008, the Secretary of Veterans Affairs shall develop and implement a comprehensive policy on the management of pain experienced by veterans enrolled for health care services provided by the Department of Veterans Affairs.

(b) SCOPE OF POLICY.—The policy required by subsection (a) shall cover each of the following:

(1) The systemwide management of acute and chronic pain experienced by veterans.

(2) The standard of care for pain management to be used throughout the Department.

(3) The consistent application of pain assessments to be used throughout the Department.

(4) The assurance of prompt and appropriate pain care treatment and management by the Department, systemwide, when medically necessary.

(5) The Department's program of research related to acute and chronic pain suffered by veterans, including pain attributable to central and peripheral nervous system damage characteristic of injuries incurred in modern warfare.

(6) The Department's program of pain care education and training for health care personnel of the Department.

(7) The Department's program of patient education for veterans suffering from acute or chronic pain and their families.

(c) UPDATES.—The Secretary shall revise the policy developed under subsection (a) on a periodic basis in accordance with experience and evolving best practice guidelines.

(d) CONSULTATION.—The Secretary shall develop the policy developed under subsection (a), and revise such policy under subsection (c), in consultation with veterans service organizations and organizations with expertise in the assessment, diagnosis, treatment, and management of pain.

(e) ANNUAL REPORT.—

(1) IN GENERAL.—Not later than 180 days after the date of the completion and initial implementation of the policy under subsection (a) and on October 1 of every fiscal year thereafter through fiscal year 2018, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the implementation of the policy developed under subsection (a).

(2) CONTENTS.—The report required by paragraph (1) shall include the following:

(A) A description of the policy developed and implemented under subsection (a) and any revisions to such policy under subsection (c).

(B) A description of the performance measures used to determine the effectiveness of such policy in improving pain care for veterans systemwide.

(C) An assessment of the adequacy of the Department's pain management services based on a survey of patients managed in Department clinics.

(D) An assessment of the Department's research programs relevant to the treatment of the types of acute and chronic pain suffered by veterans.

(E) An assessment of the training provided to Department health care personnel with respect to the diagnosis, treatment, and management of acute and chronic pain.

(F) An assessment of the Department's pain care-related patient education programs.

(f) VETERANS SERVICE ORGANIZATION DEFINED.—In this section, the term "veterans service organization" means any organization recognized by the Secretary for the representation of veterans under section 5902 of title 38, United States Code.

SEC. 5. ESTABLISHMENT OF CONSOLIDATED PATIENT ACCOUNTING CENTERS.

(a) ESTABLISHMENT OF CENTERS.—Chapter 17 of title 38, United States Code, is amended by inserting after section 1729A the following:

"§ 1729B. Consolidated patient accounting centers

"(a) IN GENERAL.—Not later than 5 years after the date of enactment of this section, the Secretary of Veterans Affairs shall establish not more than seven consolidated patient accounting centers for conducting industry-modeled regionalized billing and collection activities of the Department.

"(b) FUNCTIONS.—The centers shall carry out the following functions:

"(1) Reengineer and integrate all business processes of the revenue cycle of the Department.

"(2) Standardize and coordinate all activities of the Department related to the revenue cycle for all health care services furnished to veterans for nonservice-connected medical conditions.

"(3) Apply commercial industry standards for measures of access, timeliness, and performance metrics with respect to revenue enhancement of the Department.

"(4) Apply other requirements with respect to such revenue cycle improvement as the Secretary may specify.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1729A the following:

"1729B. Consolidated patient accounting centers.".

SEC. 6. SIMPLIFYING AND UPDATING NATIONAL STANDARDS TO ENCOURAGE TESTING OF THE HUMAN IMMUNODEFICIENCY VIRUS.

Section 124 of the Veterans' Benefits and Services Act of 1988 (38 U.S.C. 7333 note; 102 Stat. 505) and the item relating to such section in the table of contents of such Act (102 Stat. 487) are repealed.

Amend the title so as to read:

A bill to amend title 38, United States Code, to prohibit the Secretary of Veterans Affairs from collecting certain copayments from veterans who are catastrophically disabled, and for other purposes.

PURPOSE AND SUMMARY

H.R. 6445 was introduced by Representative Donald J. Cazayoux, Jr. of Louisiana on July 9, 2008. H.R. 6445, as amended, contains provisions from H.R. 6439, introduced by Representative Phil Hare of Illinois; H.R. 6122, introduced by Representative Tim Walz of Minnesota; H.R. 6366, introduced by Representative Steve Buyer of Indiana, the Ranking Member of the Committee on Veterans' Affairs; and H.R. 6114, introduced by Representative Mike Doyle of Pennsylvania.

H.R. 6445 would modernize the Department of Veterans Affairs (VA) policies regarding copayments for non-service-connected Priority Group 4 veterans who are catastrophically disabled, pain care management programs, eligibility for counseling services for family members, and requirements for informed consent for HIV testing. Additionally, this legislation would enhance the VA's ability to col-

lect third-party payments by requiring the VA establish not more than seven consolidated patient accounting centers (CPACs).

The bill would prohibit the VA from collecting copayments from veterans who are catastrophically disabled (Priority Group 4) for hospital or nursing home care and would direct the VA to establish not more than seven CPACs for conducting industry-modeled regionalized billing and collection activities.

The bill would repeal the specification that in order for family members of non-service-connected veterans to be eligible for counseling services the counseling must be essential to permit the discharge of the veteran from the hospital. It would direct the VA to develop and implement a comprehensive policy on the management of pain experienced by veterans enrolled for health care services provided by the VA and revise the policy on a periodic basis in accordance with experience and evolving best practice guidelines. The bill would also require VA to develop and revise the policy in consultation with veterans' service organizations and organizations with expertise in the assessment, diagnosis, treatment, and management of pain.

The bill would remove the requirement for written informed consent for HIV testing among veterans, thereby reducing existing barriers to the early diagnosis of HIV infection.

BACKGROUND AND NEED FOR LEGISLATION

PROHIBITING COLLECTION OF COPAYMENTS FROM CATASTROPHICALLY DISABLED VETERANS

The Veterans' Health Care Eligibility Reform Act of 1996 (Public Law 104–262) directed the VA to establish a patient enrollment system to manage the provision of care and services provided to veterans, established seven priority groups, and directed the VA to enroll veterans in accordance with the priorities listed in the law. The Department of Veterans Affairs Health Care Programs Enhancement Act of 2001 (Public Law 107–135) subsequently added a new Priority Group 8 to reflect veterans with the lowest priority to VA health care to the existing seven priority groups.

Veterans enrolled in Priority Groups 5 through 8, who are verified by the VA to be non-service connected catastrophically disabled and who have incomes above means-tested levels, may apply for enrollment into Priority Group 4. Those veterans who were previously subject to copayments are required to agree to pay those copayments after moving to Priority Group 4.

Catastrophically disabled veterans are defined as having a permanent, severely disabling injury, disorder, or disease that compromises the ability to carry out the activities of daily living to such a degree that the individual requires personal or mechanical assistance to leave home or bed or requires constant supervision to avoid physical harm to self or others. According to the VA, approximately 25,000 catastrophically disabled veterans are enrolled in Priority Group 4.

H.R. 6445 would prohibit the VA from collecting copayments from non-service connected veterans who are catastrophically disabled in Priority Group 4 for hospital or nursing home care. The very nature and severity of the disabilities experienced by these veterans often precludes them from being employed and may,

therefore, deprive them of a steady form of income. The Committee believes requiring catastrophically disabled veterans to pay copayments may cause these veterans undue financial hardship.

EXPANSION OF AUTHORITY OF SECRETARY OF VETERANS AFFAIRS TO PROVIDE COUNSELING FOR FAMILY MEMBERS OF VETERANS RECEIVING NON-SERVICE-CONNECTED TREATMENT

The Department of Veterans Affairs Health Care Programs Enhancement Act of 2001 (Public Law 107–135) consolidated and reorganized the authority for the VA to provide services to non-veterans. This Act created section 1782 to title 38, United States Code, that outlines the conditions by which the VA may provide counseling, training and mental health services to immediate family members.

Under current law, all enrolled veterans receiving care for service-connected treatment are eligible for family support services to the extent they are necessary to the veterans' treatment. Veterans being treated for non-service-connected disabilities are only eligible for these family support services if they are necessary in connection with the veteran's treatment, initiated during the veteran's hospitalization, and their continued provision on an outpatient basis is deemed essential to permit the discharge of the veteran from the hospital.

Over the past decade, VA has transformed its delivery of health care services from an inpatient-based model to an outpatient-based model. According to VA, this transformation has significantly increased its efficiencies, increased veterans' access to care, and aligned the VA with the health care industry at large. As a result, some families have become ineligible for counseling, training, and other family support services that are essential to the veterans' treatment simply because their loved ones' care was for a non-service-connected disability that was provided on an outpatient basis.

H.R. 6445 would eliminate the requirement that family support services be initiated during the veteran's hospitalization and deemed essential to permit the veteran's discharge, thus making the eligibility criteria the same for all veterans. An enrolled veteran is eligible for any needed medical treatment, regardless of whether or not the condition is service-connected. The Committee believes it is incongruent to base eligibility for needed family support services on the service-connected nature of a veteran's disability. If family support services are necessary in connection with the veteran's treatment, it should be irrelevant whether the disability under treatment is service-connected or non-service-connected and whether the treatment is provided in a hospital setting or on an outpatient basis.

H.R. 6445 would enable the VA to provide needed counseling, training and mental health services to immediate family members of these veterans. As the mental health needs of veterans continue to grow and the VA is authorized to provide treatment and support to more veterans and their families, it is likely that it will need to increase its mental health workforce to accommodate the increased demand. The Committee strongly encourages the VA to fully implement the Veterans Benefits, Health Care, and Information Technology Act of 2006 (Public Law 109–461). This Act authorized the VA to recognize and hire Licensed Professional Counselors and

Marriage and Family Therapists as mental health professionals in the VA. However, the VA has yet to adopt regulations and policies to credential and employ mental health counselors in the VA system. These qualified and licensed mental health professionals are willing and able to care for our nation's veterans and their families and will help the VA meet the additional mental health workload now and into the future.

COMPREHENSIVE POLICY ON PAIN MANAGEMENT

According to the National Center for Health Statistics, pain affects an estimated 76 million Americans, more than cancer, diabetes and heart disease combined. Uncontrolled pain is a leading cause of disability and reduced quality of life. It adversely affects every aspect of daily living. Pain patients consume health care resources at a higher rate than other groups of patients. Under-treated pain is a leading contributor to health care costs, accounting for more than $100 billion a year in health care expenses and lost productivity.

The VA recognized that early assessment and pain management treatment is fundamental to the delivery of patient-centered medicine. In November 1996, VA appointed a Multidisciplinary Pain Committee to assess the appropriateness of VA pain management policies. This Committee found that the VA lacked a systematic pain management process. To address this shortcoming, VA developed a National Pain Management Strategy in November of 1998 and in March of 1999 VA issued a guide "Pain Assessment, the 5th Vital Sign," establishing procedures for pain assessment, treatment, and outcomes of treatments in all clinical settings to ensure consistent assessment of pain.

In 2002, the VA Office of Inspector General (IG) conducted a review of VA's Pain Management Initiative to determine whether the initiative had been implemented in medical and surgical settings, pain interventions were timely and adequate, and reflected documented follow-up pain measurements. On June 10, 2002, the IG issued a report (01–00026–101) that found that VA had made significant improvements over the previous five years since the initiative was established, but also found that the extent of implementation varied and more work needed to be done. Subsequently, VA issued VHA Directive 2003–021, establishing a Pain Management Strategy to make pain management a national priority. The Directive outlined the VA's strategy as providing a system-wide VHA standard of care for pain management; ensuring that pain assessment is performed in a consistent manner; ensuring that pain assessment is prompt and appropriate to include patients and families as active participants in pain management; providing for an interdisciplinary, multi-modal approach to pain management; and, ensuring that clinicians practicing in the VA health care system are adequately prepared to assess and manage pain effectively. This Directive expired on May 31, 2008.

H.R. 6445 would require VA to develop and implement a comprehensive policy on the management of pain experienced by veterans. It would require the VA to develop the policy in consultation with veterans service organizations and organizations with expertise in the assessment, diagnosis, treatment, and management of pain.

CONSOLIDATED PATIENT ACCOUNTING CENTERS

Current law authorizes the VA to bill veterans' insurance companies (third-party collections) for non-service-connected care provided to veterans enrolled in the VA health care system. Public Law 105–33 gave VA the authority to retain these funds in the Medical Care Collections Fund (MCCF). VA can use the MCCF for providing medical services to veterans. In 2005, VA created the Mid-Atlantic CPAC in Asheville, North Carolina to help maximize its collections by using a private-sector model that is tailored to VA's billing and collection needs.

Conference Report 109–305, accompanying Public Law 109–114, directed VA to establish a Revenue Improvement Demonstration to advance revenue performance and develop a model that could be leveraged systemwide. Due to their complementary missions, VA established the Revenue Improvement Demonstration Project at the Mid-Atlantic CPAC. Approximately $12 million for fiscal year 2007 in additional collections was generated as a result of this Revenue Improvement Demonstration Project in coordination with the CPAC initiatives.

A June 2008 report from the Government Accountability Office (GAO) estimated that $1.2 to $1.4 billion dollars are going uncollected by VA. GAO reiterated its previous findings from 2001 and 2004 that VA has challenges in collecting from third-party payers, to include improper coding, delays in billing, and collections follow-up. These challenges prevent VA from maximizing its potential revenue from third-party insurance companies. However, in its 2008 report, GAO noted that the Mid-Atlantic CPAC achieved better billing performance and has been able to reduce billing times. GAO concluded that VA needs to establish standardized processes and procedures to improve timely and accurate billing and enhance collections. Effective management oversight and implementation will be key to the success of these initiatives.

The Committee believes using the best practices from the CPAC and Revenue Improvement Demonstration Project would provide systemwide improvement for VA's collection processes. H.R. 6445 would require the VA to establish, within five years, no more than seven CPACs modeled after the existing CPAC and Revenue Improvement Demonstration Project in Asheville, North Carolina. The Committee expects VA to move quickly to implement these provisions in order to have the facilities operational in a timely manner.

SIMPLIFYING AND UPDATING NATIONAL STANDARDS TO ENCOURAGE TESTING OF THE HUMAN IMMUNODEFICIENCY VIRUS

According to the Center for Disease Control (CDC), human immunodeficiency virus (HIV) is the virus that causes acquired immunodeficiency syndrome (AIDS). HIV attacks the immune system and destroys its ability to fight disease. As HIV progresses to AIDS, the body becomes increasingly susceptible to life-threatening opportunistic infections. CDC estimates 1,039,000 to 1,185,000 persons in the United States were living with HIV/AIDS at the end of 2003 and approximately 40,000 persons become infected with HIV annually. Approximately 16 to 22 million persons in the United States are tested for HIV every year. Although 38 percent to 44 percent of all adults had been tested for HIV by 2002, CDC

estimates that approximately 252,000 to 320,000 persons are unaware of their HIV infection.

The VA is the largest single provider of HIV/AIDS care in the United States. As of fiscal year 2005, there were 22,800 patients with HIV/AIDS in the VA. According to the VA's Public Health Strategic Working Group, 50 percent of HIV positive veterans had already suffered significant damage to their immune system by the time they were diagnosed as HIV positive. These patients had, on average, 3.7 years of VA care before diagnosis, indicating that there were missed opportunities to make a diagnosis at a stage when HIV treatment could have prevented many of the complications experienced by these patients.

The Veterans' Benefits and Services Act of 1988 (Public Law 100–322), requires the VA to obtain a patient's written consent before being tested for HIV. Since the enactment of Public Law 100–322, HIV testing has entered a new era. Lawmakers and public health officials are making changes to ensure that more people know their HIV status—an important consideration for maintaining their health and reducing the spread of the virus.

In September 2006, CDC released the *Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings* which recommends that diagnostic HIV testing be a part of routine clinical care in all health care settings in the United States and recommends that separate written consent for HIV screening should no longer be required. The revised recommendations contend that people who are infected with HIV but not aware of it are not able to take advantage of the therapies that can keep them healthy and extend their lives, nor do they have the knowledge to protect their sex or drug-use partners from becoming infected.

Knowing whether one is positive or negative for HIV may influence healthy decision making. Cohort studies have demonstrated that many infected persons decrease high risk behaviors once they become aware of their positive HIV status. HIV-infected persons who are unaware of their infection do not reduce risk behaviors. Because of medical treatment that lowers HIV viral load might also reduce risk for transmission to others, early referral to medical care could prevent HIV transmission in communities while reducing a person's risk for HIV-related illness and death.

H.R. 6445 would remove the statutory requirements that a patient's written consent be obtained before testing for HIV, and accompanied by pre-and post-test documented counseling. This will enable the VA to update its procedures to conform to current standard of care and afford VA the flexibility to update their screening standards.

This provision is identical to VA's legislative request in its fiscal year 2009 budget submission to update VA's HIV Testing Policy in accordance with CDC Testing Recommendations. The American Medical Association, the HIV Medicine Association, the American Academy of HIV Medicine, the American Academy of Pediatrics, the National Medical Association, and the National Association of Community Health Centers have endorsed the CDC recommendations. The Committee believes that these recommendations are appropriate for VA to implement. However, we recognize that these recommendations might change over time.

The Committee recognizes that VA is a leader in responding to the challenges of the HIV/AIDS epidemic. The Committee urges VA to continue to ensure that veterans with HIV infection receive the highest quality clinical care and preventative services and that those veterans at risk also receive appropriate counseling, assistance and preventive services to lower their risk of acquiring the infection.

HEARINGS

On June 26, 2008, the Subcommittee on Health held a legislative hearing on a number of bills introduced in the 110th Congress, including the discussion drafts of a number of provisions included in H.R. 6445, as amended. The following witnesses testified: Mr. Carl Blake, National Legislative Director, Paralyzed Veterans of America; Mr. Christopher Needham, Senior Legislative Associate, National Legislative Service, Veterans of Foreign Wars of the United States; Gerald M. Cross, M.D., FAAFP, Principal Deputy Under Secretary for Health, Veterans Health Administration, U.S. Department of Veterans Affairs, accompanied by Walter A. Hall, Assistant General Counsel, U.S. Department of Veterans Affairs and Gary M. Baker, Chief Business Officer, Veterans Health Administration, U.S. Department of Veterans Affairs. Those submitting statements for the record included: Mr. Joseph L. Wilson, Assistant Director, Veterans Affairs and Rehabilitation Commission, The American Legion; Mr. Raymond C. Kelley, National Legislative Director, American Veterans (AMVETS); Mr. Adrian M. Atizado, Assistant National Legislative Director, Disabled American Veterans; and, Ms. Barbara F. West, Executive Director, National Association of Veterans' Research and Education Foundation

SUBCOMMITTEE CONSIDERATION

On July 10, 2008, the Subcommittee on Health met in open markup session and ordered favorably forwarded to the full Committee H.R. 6445 by voice vote.

COMMITTEE CONSIDERATION

On July 16, 2008, the full Committee met in an open markup session, a quorum being present, and ordered H.R. 6445 as amended, favorably reported to the House of Representatives, by voice vote. During consideration of the bill the following amendment was considered:

An amendment in the nature of a substitute by Mr. Michaud of Maine that incorporated provisions of H.R. 6439, H.R. 6122, H.R. 6366, and H.R. 6114, was agreed to by voice vote.

COMMITTEE VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee to list the record votes on the motion to report the legislation and amendments thereto. There were no record votes taken on amendments or in connection with ordering H.R. 6445 reported to the House. A motion by Mr. Buyer of Indiana to order H.R. 6445, as amended, reported favorably to the House of Representatives was agreed to by voice vote.

COMMITTEE OVERSIGHT FINDINGS

In compliance with clause 3(c)(1) of rule XIII and clause (2)(b)(1) of rule X of the Rules of the House of Representatives, the Committee's oversight findings and recommendations are reflected in the descriptive portions of this report.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

In accordance with clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the Committee's performance goals and objectives are reflected in the descriptive portions of this report.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee adopts as its own the estimate of new budget authority, entitlement authority, or tax expenditures or revenues contained in the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

EARMARKS AND TAX AND TARIFF BENEFITS

H.R. 6445 does not contain any congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9(d), 9(e), or 9(f) of rule XXI of the Rules of the House of Representatives.

COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate on H.R. 6445 prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the following is the cost estimate for H.R. 6445 provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, July 28, 2008.

Hon. BOB FILNER,
Chairman, Committee on Veterans' Affairs,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 6445, the Veterans Health Care Policy Enhancements Act of 2008.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Sunita D'Monte.

Sincerely,

ROBERT A. SUNSHINE
(For Peter R. Orszag, Director).

Enclosure.

H.R. 6445—Veterans Health Care Policy Enhancements Act of 2008

Summary: H.R. 6445 would:

- Allow the Department of Veterans Affairs (VA) to increase testing for human immunodeficiency virus (HIV) infection in the population of veterans who use VA health care facilities,
- Require VA to establish up to seven regional accounting centers to consolidate all VA billing and collection functions related to health care,
- Prohibit VA from collecting copayments and fees from certain catastrophically disabled veterans,
- Authorize VA to provide certain mental health services to the family members and housemates of veterans being treated for a nonservice-connected condition, and
- Require VA to develop and implement a comprehensive policy on pain care.

In total, CBO estimates that implementing H.R. 6445 would cost $995 million over the 2009–2013 period, assuming appropriation of the estimated amounts. Enacting the bill would not affect direct spending or revenues.

H.R. 6445 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA) and would impose no costs on state, local, or tribal governments.

Estimated cost to the Federal Government: The estimated budgetary impact of H.R. 6445 is shown in the following table. The costs of this legislation fall within budget function 700 (veterans benefits and services).

	By fiscal year, in millions of dollars—					
	2009	2010	2011	2012	2013	2009–2013
CHANGES IN SPENDING SUBJECT TO APPROPRIATION						
Testing for Human Immunodeficiency Virus:						
Estimated Authorization Level	43	114	188	265	343	953
Estimated Outlays	38	107	181	257	335	918
Patient Accounting Centers:						
Estimated Authorization Level	7	24	4	0	0	35
Estimated Outlays	6	22	6	−4	−6	24
Copayments for the Catastrophically Disabled:						
Estimated Authorization Level	6	6	6	6	6	30
Estimated Outlays	6	6	6	6	6	30
Counseling for Family Members:						
Estimated Authorization Level	4	5	5	5	5	24
Estimated Outlays	4	4	5	5	5	23
Total Changes:						
Estimated Authorization Level	60	149	203	276	354	1,042
Estimated Outlays	54	139	198	264	340	995

Basis of estimate: CBO assumes that the legislation will be enacted near the end of fiscal year 2008, that the estimated amounts will be appropriated each year, and that outlays will follow historical spending patterns for similar programs.

TESTING FOR HIV

Section 6 would eliminate a rule prohibiting VA from conducting widespread testing for HIV infection in the population of veterans who use VA health care facilities. It also would eliminate current

requirements for separate written consent for HIV tests and pre- and post-test counseling.

Based on data from VA, CBO estimates that under section 6, the number of HIV tests administered by VA would increase significantly, from the current annual level of about 125,000 tests to 200,000 in 2009 and to 250,000 a year over the 2010–2013 period. Based on studies of veterans enrolled in VA health care, CBO expects that increased testing would lead to an increase in the number of newly diagnosed veterans and that those veterans would be identified earlier in the course of the disease.[1] We expect that people who are tested for HIV at, and receive general care in, VA health care facilities would prefer to maintain continuity of care with VA health care providers, and thus would be treated by VA for HIV disease. Based on data from VA and the Kaiser Family Foundation, CBO estimates that the average cost of treatment in 2009 would be $18,000 per patient in the early stages of HIV infection, and $35,000 per patient in the advanced stages of the disease.

CBO estimates that under the bill, VA would start providing comprehensive HIV treatment to an additional 1,600 newly diagnosed veterans in 2009 at an average cost of $27,000 per person. By 2013, CBO estimates that the number of additional veterans being treated for HIV would grow to about 12,000. Because an increasing proportion of those veterans would be diagnosed in the early stages of the disease when treatment is less expensive, the average cost of treatment, before considering the effects of inflation, would decrease over time. Adjusting for inflation, CBO estimates that implementing section 6 would cost about $920 million over the 2009–2013 period, assuming appropriation of the necessary funds.

PATIENT ACCOUNTING CENTERS

Section 5 would require VA to establish up to seven consolidated patient accounting centers (CPACs) within the next five years. CPACs would be required to apply commercial industry standards to coordinate and standardize billing and collections related to health care. In total, CBO estimates that implementing this section would cost $24 million over the 2009–2013 period, assuming appropriation of the estimated amounts.

In 2006, VA established a CPAC in North Carolina, and the agency plans to expand the area it serves in 2008 and 2009. Based on information from VA, CBO expects that VA would begin establishing three CPACs in 2009, one in 2010, and the remaining two in 2011, and that all CPACs would be fully operational by the end of 2013. CBO also expects that there would be no net change in the overall number of employees working in billing and collection activities; some existing employees would move to CPACs, other existing employees would transition to different functions at their current location, and some new employees would be hired.

[1] Ronald O. Valdiserri, Fred Rodriguez, and Mark Holodniy, "Frequency of HIV Screening in the Veterans Health Administration: Implications for Early Diagnosis of HIV Infection," *AIDS Education and Prevention,* vol. 20, no. 3 (2008), pp. 258–264; and Douglas K. Owens and others, "Prevalence of HIV Infection Among Inpatients and Outpatients in Department of Veterans Affairs Health Care Systems: Implications for Screening Programs for HIV," *American Journal of Public Health,* vol. 97, no. 12 (2007), pp. 2173–2178.

CBO estimates that VA would require additional appropriations to retain those current employees who would transition to other functions at the facilities where they are employed, and that this period of transition would take nine months. Based on information from VA and assuming appropriation of the estimated amounts, CBO estimates that the total salary costs for those employees would be $12 million in 2009 and would grow to $25 million in 2012, before declining to $13 million in 2013, when most CPACs would be operational. CBO estimates that other one-time costs of implementing CPACs—such as training, leases and start-up costs for office space, and information technology—would have a similar trend; initial costs would be $18 million in 2009, grow to $43 million in 2011 and 2012, and decline to $22 million in 2013, assuming appropriation of the estimated amounts.

In addition to CPACs, CBO expects that VA would require a small office at the VA headquarters in Washington, D.C., to oversee the regional CPACs. Based on information from VA, CBO estimates that the office would require 10 additional staff in 2009 at a cost of $1 million but that staff would grow as CPACs become operational to about 33 people by 2013 with recurring costs of $4 million a year, assuming appropriation of the estimated amounts.

Based on VA data on the growth in medical care collections (collections from third parties, copayments, and other fees) from the existing CPAC, CBO estimates that under the bill VA would collect an additional $30 million in 2009, which would rise to about $175 million in 2013. Under current law, those collections may be retained by the department and used to provide medical care and to offset expenses related to billing and collections. Thus, CBO estimates that much of the five-year costs of implementing CPACs would be offset by the resulting increase in collections; in the initial years implementation costs would exceed the additional collections, but starting in 2012 these collections would exceed the implementation costs. Assuming appropriation of the estimated amounts, CBO estimates that implementing CPACs would have net costs of $24 million over the 2009–2013 period.

COPAYMENTS FOR THE CATASTROPHICALLY DISABLED

Section 2 would prohibit the collection of copayments and other fees from catastrophically disabled veterans who receive medical or nursing home care from VA. Catastrophically disabled veterans are those who have a permanent, severely disabling condition that compromises their ability to carry out the activities of daily living to such a degree that they require assistance to leave their homes or require constant supervision to avoid physical harm to themselves or others.

Data from VA show that, in 2006, the department collected about $6 million in medical care and nursing home fees from catastrophically disabled veterans who are priority category 4 veterans because their disabilities are not related to military service. Because those copayments and fees are fixed and the population of those veterans has been relatively stable over the past several years, CBO estimates that implementing this provision would decrease collections by $6 million per year. Such collections are offsets to discretionary appropriations. As part of the annual appropriations process, the Congress gives VA authority to spend those collections.

Therefore, maintaining the same level of health care services for veterans would necessitate additional funding each year to make up for the loss of copayments under this bill. Thus, CBO estimates that implementing this provision would cost $30 million over the 2009–2013 period.

COUNSELING FOR FAMILY MEMBERS

Section 3 would expand VA's authority to provide consultations, professional counseling, training, and other necessary mental health services to the family members or housemates of certain veterans being treated for nonservice-connected conditions. Under current law, such services are only authorized if they began during the veteran's hospitalization and are necessary on an outpatient basis to permit the veteran's discharge from the hospital. The bill would strike those restrictions and allow VA to provide such services on the same basis to all veterans, regardless of whether the condition being treated is service-connected or not.

In 2007, the VA provided services to about 5,000 family members or housemates of roughly 2.15 million veterans (a rate of 0.23 percent) at a cost of about $3 million. Another 2.65 million veterans were treated in 2007 for nonservice-connected conditions, but their family members or housemates were not eligible for mental health services. CBO expects that under the bill, the currently ineligible family members or housemates would require such services at the same rate they are being provided to those who are currently eligible.

After adjusting for inflation and growth in the number of veterans requiring treatment, CBO estimates that under the bill VA would provide mental health services to an additional 6,700 people a year at an annual cost of almost $5 million, on average, over the 2009–2013 period. CBO estimates that implementing this provision would cost $23 million over the 2009–2013 period, assuming appropriation of the estimated amounts.

COMPREHENSIVE POLICY ON PAIN MANAGEMENT

Section 4 would require VA to develop and implement a comprehensive policy on pain care at all VA health care facilities, under which VA would assess and appropriately treat acute and chronic pain. The department also would be required to make annual reports on the policy to the Congress. VA reports that it has implemented appropriate pain assessment and management protocols at its medical facilities. Thus, CBO estimates that implementing the provision would cost less than $500,000 over the 2009–2013 period for the production of annual reports, assuming availability of appropriated amounts.

Intergovernmental and private-sector impact: H.R. 6445 contains no intergovernmental or private-sector mandates as defined in UMRA and would impose no costs on state, local, or tribal governments.

Previous CBO estimate: On January 15, 2008, CBO transmitted a cost estimate for S. 2160 as ordered reported by the Senate Committee on Veterans' Affairs on November 14, 2007. Section 3 of that bill is similar to section 4 of H.R. 6445 and CBO estimated it would have no costs, but the House bill would impose reporting requirements that CBO estimates would have small annual costs.

On August 23, 2007, CBO transmitted a cost estimate for S. 1233 as ordered reported by the Senate Committee on Veterans' Affairs on June 27, 2007. Section 303 of that bill is similar to section 2 of H.R. 6445. Their estimated costs over a five-year period are identical, except that CBO assumes a later enactment date for H.R. 6445.

Estimate prepared by: Federal Costs: Sunita D'Monte and Alexis Miller; Impact on State, Local, and Tribal Governments: Lisa Ramirez-Branum; Impact on the Private Sector: Daniel Frisk.

Estimate approved by: Theresa Gullo, Deputy Assistant Director for Budget Analysis.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates regarding H.R. 6445 prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act would be created by H.R. 6445.

CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause 3(d)(1) of rule XIII of the Rules of the House of Representatives, the Committee finds that the Constitutional authority for H.R. 6445 is provided by Article I, section 8 of the Constitution of the United States.

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 1. Short title

This section would provide the short title of H.R. 6445 as the "Veterans' Health Care Policy Enhancement Act of 2008."

Section 2. Prohibition on collection of certain copayments from veterans who are catastrophically disabled

This section would add a new subsection to section 1710 of chapter 17 of title 38, United States Code, which would prohibit the VA from collecting copayments from veterans who are non-service connected catastrophically disabled (Priority Group 4) for hospital and nursing home care.

Section 3. Expansion of authority of Secretary of Veterans Affairs to provide counseling for family members of veterans receiving non-service-connected treatment

This section would repeal the requirement currently in subsection (b) of section 1782, United States Code, that in order for family members of non-service-connected veterans to be eligible for

counseling services, the counseling must be essential to permit the discharge of the veteran from the hospital.

Section 4. Comprehensive policy on pain management

This section would direct the VA to develop and implement a comprehensive policy on the management of pain experienced by veterans enrolled for health care services provided by the VA. It further directs the VA to revise the policy on a periodic basis in accordance with experience and evolving best practice guidelines. The VA should develop and revise the policy in consultation with veterans service organizations and other organizations with expertise in the assessment, diagnosis, treatment, and management of pain. In addition, this section requires the VA to submit a report on the implementation of the policy to the Committee not later than 180 days after the date of the completion and initial implementation of the policy and on October 1 of every fiscal year thereafter through fiscal year 2018.

Section 5. Establishment of consolidated patient accounting centers

This section would add a new section, 1729B to title 38, United States Code, which would require the VA to establish not more than seven consolidated patient accounting centers for conducting industry-modeled regionalized billing and collection activities not later than 5 years after the enactment of this act.

Section 6. Simplifying and updating national standards to encourage testing of the Human Immunodeficiency Virus

This section would repeal section 124 of the Veterans' Benefits and Services Act of 1988 (Public Law 100–322) to remove the requirement for written informed consent for HIV testing among veterans.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

TITLE 38, UNITED STATES CODE

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PART II—GENERAL BENEFITS

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CHAPTER 17—HOSPITAL, NURSING HOME, DOMICILIARY, AND MEDICAL CARE

SUBCHAPTER I—GENERAL

Sec.
1701. Definitions.

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SUBCHAPTER III—MISCELLANEOUS PROVISIONS RELATING TO HOSPITAL AND NURSING HOME CARE AND MEDICAL TREATMENT OF VETERANS

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SUBCHAPTER II—HOSPITAL, NURSING HOME, OR DOMICILIARY CARE AND MEDICAL TREATMENT

§ 1710. Eligibility for hospital, nursing home, and domiciliary care

(a) * * *

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(h) Notwithstanding any other provision of this section, a veteran who is catastrophically disabled shall not be required to make any payment otherwise required under subsection (f) or (g) for the receipt of hospital care or nursing home care under this section.

[(h)**]** *(i)* Nothing in this section requires the Secretary to furnish care to a veteran to whom another agency of Federal, State, or local government has a duty under law to provide care in an institution of such government.

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SUBCHAPTER III—MISCELLANEOUS PROVISIONS RELATING TO HOSPITAL AND NURSING HOME CARE AND MEDICAL TREATMENT OF VETERANS

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§ 1729B. Consolidated patient accounting centers

(a) IN GENERAL.—Not later than 5 years after the date of enactment of this section, the Secretary of Veterans Affairs shall establish not more than seven consolidated patient accounting centers for conducting industry-modeled regionalized billing and collection activities of the Department.

(b) FUNCTIONS.—The centers shall carry out the following functions:

(1) Reengineer and integrate all business processes of the revenue cycle of the Department.

(2) Standardize and coordinate all activities of the Department related to the revenue cycle for all health care services furnished to veterans for nonservice-connected medical conditions.

(3) Apply commercial industry standards for measures of access, timeliness, and performance metrics with respect to revenue enhancement of the Department.

(4) Apply other requirements with respect to such revenue cycle improvement as the Secretary may specify.

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SUBCHAPTER VIII—HEALTH CARE OF PERSONS OTHER THAN VETERANS

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§ 1782. Counseling, training, and mental health services for immediate family members

(a) * * *

(b) COUNSELING FOR FAMILY MEMBERS OF VETERANS RECEIVING NON-SERVICE-CONNECTED TREATMENT.—In the case of a veteran who is eligible to receive treatment for a non-service-connected disability under the conditions described in paragraph (1), (2), or (3) of section 1710(a) of this title, the Secretary may, in the discretion of the Secretary, provide to individuals described in subsection (c) such consultation, professional counseling, training, and mental health services as are necessary in connection with that treatment [if—

[(1) those services were initiated during the veteran's hospitalization; and

[(2) the continued provision of those services on an outpatient basis is essential to permit the discharge of the veteran from the hospital].

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VETERANS' BENEFITS AND SERVICES ACT OF 1988

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) * * *

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

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TITLE I—HEALTH-CARE PROGRAMS

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PART C—MATTERS RELATING TO AIDS

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[SEC. 124. RESTRICTION ON TESTING FOR INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS.

[(a) GENERAL RULE.—Except as provided in subsection (b), the Secretary of Veterans Affairs may not during any fiscal year conduct a widespread testing program to determine infection of humans with the human immunodeficiency virus unless funds have been appropriated to the Department of Veterans Affairs Department of Veterans Affairs specifically for such a program during that fiscal year.

[(b) VOLUNTARY TESTING.—(1) The Secretary shall provide for a program under which the Department of Veterans Affairs offers each patient to whom the Department is furnishing health care or services and who is described in paragraph (2) the opportunity to be tested to determine whether such patient is infected with the human immunodeficiency virus.

[(2) Patients referred to in paragraph (1) are—

[(A) patients who are receiving treatment for intravenous drug abuse,

[(B) patients who are receiving treatment for a disease associated with the human immunodeficiency virus, and

[(C) patients who are otherwise at high risk for infection with such virus.

[(3) Subject to the consent requirement in paragraph (4) and unless medically contraindicated, the test shall be administered to each patient requesting to be tested for infection with such virus.

[(4) A test may not be conducted under this subsection without the prior informed and separate written consent of the patient tested. The Secretary shall provide pre- and post-test counseling regarding the acquired immune deficiency syndrome and the test to each patient who is administered the test.]

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